GALindo, Francisco

1300807-000

DoL- 4/4/2013

Misc.,

THE HIPAA authorization

Complaint

PROPERTY DAMAGE RELEASE

KNOW ALL BY THESE PRESENTS:

That the Undersigned, being of lawful age, for sole consideration of Nine hundred Ninety one dollars + 76/100 Dollars ($ 991.76) to be paid to Sixta Rios, do/does hereby and for my/our/its heirs, executors, administrators, successors and assigns release, acquit and forever discharge Dept of Public Safety, Steven Martens, General Service Dept of NM + NM State Risk Management Division and his, her, their, or its agents, servants, successors, heirs, executors, administrators and all other persons, firms, corporations, associations or partnerships of and from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever, which the undersigned now has/have or which may hereafter accrue on account of or in any way growing out of any and all known and unknown, foreseen property damage and the consequences thereof resulting or to result from the occurrence on or about the 4th day of April, 2013, at or near Jefferson Blvd in Abq NM

It is understood and agreed that this settlement is the compromise of a doubtful and disputed claim, and that the payment is not to be construed as an admission of liability on the part of the party or parties hereby released, and that said released parties deny liability and intend merely to avoid litigation and buy their peace. The undersigned further declare(s) and represents(s) that no promise, inducement or agreement not herein expressed has been made to the undersigned, and that this Release contains the entire agreement between the parties hereto, and that the terms of this Release are contractual and not a mere recital.

WITNESS(ES):

SIGNATURE(S):

Witness — Signature

Date — Signature

NOTARY: State of New Mexico County of Bernalillo ; SS

On this 29th day of May, 2013, before me appeared Sixta Rios

who is known to be the person(s) named herein and who voluntarily executed this release.

Notary Signature — Date Commission Expires: May 14, 2017

ARAMARK
Healthcare Technologies

To whomever it may concern.

This letter is to verify hours missed for Francisco Galindo for the incident that occurred on April 4 2013. Francisco missed a total of 50 hours at a rate of $21.63 during the period of 4/4/13 -5/24/13 when he was finally released from medical care.

Joe Hatleli | Imaging Service Director of Diagnostic Imaging
ARAMARK Healthcare Technologies
10510 Twin Lakes Parkway | Charlotte, NC 28269

HIPAA COMPLIANT AUTHORIZATION TO OBTAIN MEDICAL RECORDS

MEDICAL PROVIDER/HOSPITAL: All Doctors + Hospital

ADDRESS:

Sedgwick CMS

For purposes of evaluating a claim made by me and/or preparing and conducting a trial on the issues concerning a claim, you are hereby authorized to furnish Keenan & Associates, Inc. any and all medical information which may be requested concerning my physical condition and treatment therefore, diagnosis, prognosis, and any and all records, files or other documentation concerning the treatment, prescription, consultation or other advisory visits or events (collectively referred to as the "Records", including bills) that pertain to:

PATIENT NAME: Francisco Galindo

PATIENT DOB: 6-27-86 **PATIENT SSN:** _____

- The records covered by this HIPAA Compliant Authorization cover the time period beginning five (5) years prior to the date of last treatment through completion of treatment.
- The records shall specifically include, but shall not be limited to, such condition and treatment as may pertain to the automobile accident/loss/claim of 4-4-13.
- This HIPAA Compliant Authorization shall also allow NM State Risk Mgmt and/or **Keenan & Associates, Inc.** or any physicians appointed by it to examine your records concerning said condition or treatment. The information covered by this Authorization includes, but is not limited to, reports, records, test results, X-rays, and any other diagnostic testing, whether in your possession or available to you. Copies of this Authorization shall be considered as valid as the original. This information is being requested for the purpose of evaluating a claim made by me and/or preparing and conducting a trial on the issues concerning this claim. This Authorization shall be valid for the duration of the claim. This is not a release of claims for damages. If further understand that I am entitled to a copy of this Authorization and acknowledge receipt by signing below. I acknowledge that the information disclosed pursuant to this
- Authorization may be re-disclosed by NM State Risk Mgmt and/or **Keenan & Associates, Inc.** pursuant to applicable law and may no longer be protected by the Health Insurance Portability and Accessibility Act (HIPAA).

I acknowledge that I have the right to revoke this Authorization. A revocation of this Authorization must be in writing and sent, via regular U.S. mail, postage pre-paid to: NM State Risk Mgmt and/or **Keenan & Associates, Inc.,**

P0 Box 14590, Albuquerque, NM 87191.

The revocation of this Authorization shall be effective upon receipt and will be prospective only.

I acknowledge that I am aware that the consequences of my not signing this Authorization can include a delay in the processing/resolution of the claim, a potential denial of the claim, or other consequences recognized by applicable state law and/or the insurance policy at issue.

PATIENT SIGNATURE _____ **DATE** 5-29-13

PRINT PATIENT NAME _____

Personal Representatives Section: If a personal representative executes this form on behalf of the patient, that representative warrants that he or she has authority to sign this form on the basis of.

SIGNATURE _____